DOCUMENT RESUME

ED 023 131 24 CG 003 106

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A Method of Self-Evaluation for Counselor Education. Final Report.

Georgia Univ., Athens. Coll. of Education.

Bureau No-BR-7-D-001

Pub Date 29 Feb 68

Grant-OEG-2-7-070001-3140

Note-89p.

EDRS Price MF-$0.50 HC-$4.55

Descriptors-*Counselor Evaluation, *Counselor Training, Empathy, *Evaluation Techniques, Practicums, *Self Evaluation, *Test Construction, Test Validity, Therapeutic Environment

Identifiers-Tennessee Self Concept Scale, Therapeutic Conditions Training, Truax Scales

A pretest-posttest control group design was used to test the value of employing four psychotherapeutic interaction scales for self-evaluation. Self-evaluation of the counselor-offered conditions empathy, positive regard, genuineness and intensity of interpersonal contact during the live counseling sessions of 44 counselors were compared with the supervisor's evaluations of the tape recorded sessions. Findings were: (1) gain in counseling performance was significant on all scales for the experimental group but on only two scales for the control group; (2) the amount of gain for the experimental group was significantly higher than that of the control groups on only one scale (Empathy) (this held true for both experienced and inexperienced counselors); (3) counselor/supervisor evaluations showed highly significant concurrent validity; and (4) basic counselor personality orientations such as self-concept strength and defensiveness generally did not affect accuracy of self-evaluation. (AUTHOR)

PA24
BR-7-D-0

Final Report

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A Method of Self-Evaluation for Counselor Education

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George M. Gazda
Project Sponsor

University of Georgia

Athens, Georgia

February, 1968

The research reported herein was performed pursuant to a grant with the Office of Education, U. S. Department of Health, Education, and Welfare. Contractors undertaking such projects under Government sponsorship are encouraged to express freely their professional judgment in the conduct of the project. Points of view or opinions stated do not, therefore, necessarily represent official Office of Education position or policy.

ED023131

U. S. Department of
Health, Education, and Welfare

Office of Education
Bureau of Research

CG 003 106

ACKNOWLEDGMENTS

Since any attempt to list all persons who made valuable contributions to this study would be an impossible undertaking, I would like to express my most sincere appreciation to the many, and to specifically acknowledge the aid of:

Dr. George M. Gazda, who served as sponsor for the project and without whose aid and counsel the project would not have been possible.

Dr. Charles B. Truax, whose research and publications form the heart of the present study. Dr. Truax generously provided suggestions, reprints of his own work, and permission to reproduce the Psychotherapeutic Interaction Scales.

Dr. Joseph C. Bledsoe, who contributed many hours of consultation on the statistical procedures used in the study.

Mr. Jack R. Crisler, Dr. Kathleen L. Davis, Miss Judy A. Gavin, Dr. Robert L. Mason, Mr. William Megathlin, Dr. Thomas J. Michels, and Dr. Harry Padgett who served as judges and practicum supervisors.

Dr. Jonell H. Folds, who provided aid and direction during the incubation stage of the study.

The forty-four counselors who generously gave their time and cooperation as subjects for the study.

Mrs. Lou Martin, the author's wife, who created the cover design, prepared the manuscripts and provided support and encouragement.

Donald G. Martin

Athens, Georgia
February, 1968

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CHAPTER I

Introduction

Of all the experiences contributing to the preparation of counselors, the supervised practicum appears to be the most helpful. It provides a unique opportunity for the counselor-in-training to explore his beliefs, add to his self-knowledge, and enhance his professional growth.

Harmon and Arnold (1960) found that between one-fourth and one-third of a group of fifty counselors-in-training mentioned "more counseling practicum experience" as a suggestion for improvement of counselor education programs. One year after completing an NDEA Counseling and Guidance Institute, counselors rated field practicum work as the most valuable aspect of their preparation (Baker, 1962). Thornton (1963) found that former counselors-in-training expressed a need for additional and intensive practicum experience. Two years after an NDEA Counseling and Guidance Institute, counselors indicated that counseling practicum was the most meaningful experience they had received (Munger, Brown & Needham, 1964).

The counseling practicum has taken such a central role in counselor education that the American Personnel and Guidance Association's *Standards for the Preparation of School Counselors* (1961) calls for supervised practice to make up approximately one-fourth of the entire counselor education program. The American Psychological Association's Division of Counseling and Guidance 1952 position paper states that the practicum is in some respects the most important phase of the whole counselor training process.

The purpose of this study was to investigate the value of a method of counselor self-evaluation which would serve to improve counseling performance during the course of the practicum and, at a later time, afford a means by which counselors in the field could examine, criticize, and improve their professional performance.

The Problem

The problem of this study was to investigate a method of counselor self-evaluation as a counselor education device. The primary objective was to determine the effect on the counseling performance of counselors-in-training (hereafter referred to as counselors) of formalized and concrete self-evaluation of live counseling sessions using four Psychotherapeutic Interaction Scales (Truax, 1961b, 1962c, 1962d, 1962e).

Secondary objectives were to: (1) investigate the relationship between the counselor's strength of self-concept and accuracy of self-evaluation; (2) investigate the relationship between the counselor's degree of defensiveness and accuracy of self-evaluation; and (3) determine the reliability of four Psychotherapeutic Interaction Scales when used for self-evaluation by counselors.

Significance of the Study

Leaders in the field of Counselor Education have pointed out the need for more self-study, both personally and professionally by counselors (Arnold, 1962; Dugan, 1961; Hill, 1965). Indeed, the development of the ability of evaluating one's performance in an objective and constructive manner seems to lie at the heart of the counseling practicum experience. Two particular points of concern have been stressed: (1) the counselor should develop the ability to examine, criticize and improve upon his own counseling performance (Boy & Pine, 1966; Dreikurs & Sonstegard, 1966; Hansen, 1965; Hansen & Moore, 1966; Patterson, 1964; Peters, 1963; Truax, 1965; Truax, Carkhuff, & Douds, 1964), and (2) the counselor should receive immediate and concrete feedback on his performance (Carkhuff & Truax, 1965; Dreikurs & Sonstegard, 1966; Miller & Oetting, 1966; Truax, 1965; Truax, Carkhuff, & Douds, 1964).

Despite the fact past studies have indicated that counselor self-evaluations can be both valid and reliable (Dole, 1964; Drucker & Remmers, 1949), only a few reports of the specific application of a self-evaluation technique to counselor training could be found (Carkhuff & Truax, 1965; Truax, 1965; Truax, Carkhuff, & Douds, 1964). None of these suggested the use of self-evaluative techniques with live interviews.

The need for a method of counselor self-evaluation extends beyond the training program. Customarily, the inservice supervision of counselors is conducted through staff meetings, review of tape recorded counseling sessions, and consultation with available counselor educators (Boy & Pine, 1966; Hansen & Moore, 1966). There are many instances, however, when counselor supervision is impractical or impossible. In some college and university counseling center, for example, the staff size and counseling load limit supervision; and some elementary and secondary schools are too isolated for easy consultation and supervision. Thus, self-evaluation is needed to enable counselors to evaluate their own efforts, and such a system should facilitate personal and professional growth.

Hypotheses and Basic Assumptions

General Null Hypotheses

In view of the problem as stated, the following null hypotheses were formulated:

1. There is no significant difference between the mean supervisor evaluations of the tape recorded counseling sessions of Groups I and II for counseling sessions conducted during the first and last one-third of the practicum training.
2. There is no positive correlation between the counselors' self-evaluations of their performance in live counseling sessions and their supervisors' evaluations of tape recordings of the same counseling sessions.

3. The counselor's strength of self-concept, as measured by pretesting with the Tennessee Self Concept Scale, does not show a positive correlation with his accuracy of self-evaluation of counseling performance (as determined by counselor/supervisor agreement on evaluations).
4. The counselor's degree of defensiveness, as measured by pretesting with the Tennessee Self Concept Scale, does not show a positive correlation with his accuracy of self-evaluation of counseling performance (as determined by counselor/supervisor agreement on evaluations).

Basic Assumptions

In testing the hypotheses involved in this study, the following assumptions were made:

1. Accuracy in self-evaluation would be demonstrated whenever there was significant agreement between the counselor's self-evaluation and the supervisor's evaluation of the same counseling session.
2. The influence of concrete, immediate feedback on counseling performance would improve the counselors' abilities to offer high levels of the therapeutic conditions measured by the Scales.
3. Counselors who had high measured strength of self-concept would be secure enough to admit to awareness all relative self-evaluative information and thus be more accurate in their self-evaluations than counselors with low measured strength of self-concept.
4. Counselors who had low measured defensiveness would be less motivated to deny and distort perceived experiences and would thus be more accurate in their self-evaluations than counselors with high measured defensiveness.

5. The instruments used in this study yield valid and reliable measures for testing the hypotheses.
6. Measures to assure anonymity of subjects, their evaluations, and their test scores motivated the subjects to respond with frankness and honesty in their self-evaluations and self-concept reports.
7. The forty-four subjects used in the study comprise a representative sample of counselors at the University of Georgia.

Definition of Terms

The following definitions apply to certain terms which are used throughout this study:

Self-concept

The self-concept may be thought of as an organized configuration of perceptions of the self which are admissible to awareness (Rogers, 1951). In relation to the person who is psychologically adjusted (i.e., high self-concept or ego-strength), Rogers states that "...the secure self serves as a guide to behavior by freely admitting to awareness, in accurately symbolized form, all the relevant evidence of his experiences" (1951, p. 498). In Rogers' discussion of the neurotic individual, he states that the person with a negative self-concept denies contradictory evaluations by selecting and stressing other perceptions (1951, p. 505).

Self-evaluation

The term self-evaluation refers to the counselor's evaluation of his own live counseling session with a client, judged as a whole in retrospect, immediately following the session.

Accuracy of Self-evaluation

The supervisors' evaluations of the tape recorded interviews are taken as valid and reliable measures of counseling performance. The counselor's accuracy of self-evaluation is judged by the correlation between his self-evaluations and his supervisor's evaluations of the counselor's tape recorded session.

Defensiveness

Rogers (1951, p. 516) states that "defense involves a denial or distortion of perceived experience to reduce the incongruity between the experience and the structure of the self." In this study, degree of defensiveness is conceptualized as the extent to which the individual tends to deny or distort perceived experiences as measured by the Tennessee Self Concept Scale.

Limitations of the Study

All conclusions which are drawn from the data gathered in this study are limited to populations similar to those from which the subjects were drawn, to the procedures used, and to the instruments used to measure performance and responses.

The use of self-report data such as yielded by the Tennessee Self Concept Scale, in lieu of observable behavior data, is recognized as a limitation. Support can be found, however, in both theory and research for using self-report as a subjective measure of self-perception (Bills, n.d.; Wylie, 1961).

It is further recognized that by the nature of the instruments used, the self-concept measured will be that which the subject consciously or pre-consciously is willing to expose (Lecky, 1951). Attempts were made to minimize guarded or socially acceptable responses by assuring the subjects that the information would remain as anonymous to the investigator as possible (through the use of code numbers) and that it would not affect their class grades.

The psychotherapeutic relationship is a most difficult, though much needed, research topic. The instruments used and the variables investigated, though they seem to be the best available to date, are certain to be modified and improved with time (Carkhuff, 1963; Rogers, 1957).

CHAPTER II

Review of Literature

The literature pertaining to this study may be summarized in three categories: (1) self-evaluation techniques; (2) psychotherapeutic variables to be studied; and (3) practicum training and counselors' self-concepts.

Self-Evaluation Techniques

The literature related to the use of self-evaluation dates back many years. Findings have been that: (1) ratings are dependent upon the nature of the trait rated and the familiarity of the rater with the trait (Mays, 1954); (2) evaluations may be affected by character traits of the evaluator (Jackson, 1929); (3) individuals tend to show consistency in self-evaluation, even if they over- or under-rate themselves (Hoffman, 1923; Hollingsworth, 1916); (4) self-insight into adjustment is not reliable for selection [for therapy] (Powell, 1948).

The need and value of self-evaluation for counseling practicum supervision is emphasized by Patterson. Patterson (1964, p. 47) feels that it is desirable for counselors to "develop the habit of self-observation and self-evaluation" and not be dependent upon the supervisor. This need is stressed by many leaders in counselor education (Carkhuff & Truax, 1965; Dreikurs & Sonstegard, 1966; Miller & Oetting, 1966; Truax, 1965; Truax, Carkhuff, & Douds, 1964).

In an attempt to predict the effectiveness of future counselors, Dole (1964) found a specially constructed Self-Appraisal Form to be a reliable predictor, and his data suggested that effective counselors were able to distinguish appropriate counselor qualities and skills and to evaluate their work objectively.

Drucker and Remmers (1949), in studying self-ratings of university counselors, found self-ratings of personal and vocational counseling to be valid.

Truax (1965), at a symposium on non-traditional preparation for helping relationships, suggested the use of evaluation and self-evaluation as a means of shaping the counselors' responses toward a higher level of empathy, warmth, and genuineness. Carkhuff and Truax (1965) later reported this procedure effective in increasing levels of these counselor-offered conditions.

Psychotherapeutic Variables

Despite the seemingly diverse multitude of psychotherapeutic theories and practices, there have emerged several recurring cross-theory themes attempting to identify and quantify the effective ingredients of a therapeutic encounter. Psychoanalytic theorists such as Alexander (1948), Halpern and Lesser (1960), Ferenczi (1930), and Schafer (1959); client-centered theorists such as Dymond (1949), Jourard (1959), and Rogers (1951, 1957); as well as eclectic theorists such as Hobbs (1962), Rausch and Bordin (1957), Strunk (1957), and Strupp (1960) have stressed the importance of the therapist's ability to sensitively and accurately understand the patient. They have also emphasized that the therapist accurately and empathically know the client's "being" and respond in such a manner as to communicate this deep understanding. Also, most have focused upon the importance of non-possessive warmth and acceptance of the client by the therapist and have emphasized that the therapist be integrated, mature or genuine within the therapeutic encounter (Truax & Carkhuff, 1963, p. 2).

Statements of the Various Theoretical Positions

Rogers' article (1957) on the "necessary and sufficient conditions of therapeutic personality change" has proven to be of major significance. Although most of his postulates had been recognized by a variety of theorists previously, this appears to be the first organized statement of theory as such, and has had far reaching heuristic influence in generating research. Based upon both his own and his colleagues' clinical experiences and research findings, Rogers (1957, p. 95) proposed the following conditions which, according to him, were "necessary to initiate constructive personality change, and which, taken together, appear to be sufficient to inaugurate that process":

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. [Rogers subsequently modified this to focus upon the client's perception of the communication, whether intended by the therapist or not (Rogers, 1959).]

Although Rogers has consistently maintained a flexible position in regard to theory modification in accordance with increasing knowledge and research findings, he emphasizes in this statement that "...no other conditions are necessary. If these six conditions exist and continue over a period of time, change will follow" (1957, p. 96). He goes on to say that these conditions apply to any situation in which constructive personality change occurs, thus indicating their applicability to all types of clients, therapists and theoretical orientations.

In examining this theory, one is immediately moved to question whether these conditions are indeed both necessary and sufficient for therapeutic personality change. Another major question is the unknown factor loading or beta weights of the proposed conditions (Carkhuff, 1963). While Rogers' general formulations imply that all of the conditions have equal weight, he is cognizant of the possibility that "... empirical studies will no doubt make possible much more refinement of the hypotheses" (Rogers, 1957, p. 100).

While Rogers' theoretical position may have some outstanding weaknesses, it has, however, had an impact of major proportions upon research trends in counseling and psychotherapy.

As an illustration of the psychoanalytic point of view, Harper (1959, p. 9) proposes the following elements as common to all forms of psychotherapy:

1. one or more persons (patients) with some awareness of neglect or mishandled life problems;
2. one or more persons (therapists) with relative lack of disturbance who perceived the distress of the patients and believe themselves capable of helping the patients to reduce distress;
3. a positive regard of patients for therapists and vice versa;
4. understanding and empathy of therapist for patient;
5. perception by patient of the positive regard for and empathic understanding of him by the therapist;
6. provision by the therapist of more correct information for the patient regarding the realities of his environment;
7. help that the patient may achieve a better self-evaluation;
8. emotional catharsis;
9. a gradually increasing number of tasks for the patient to perform between therapy sessions in applying new information about himself and his environment; and
10. a gradual learning by the patient of independence of the therapist.

Thus, Harper conceptualizes psychoanalytic therapy in terms of the kinds and processes of the gains which the client can make and also focuses upon the common re-learning elements which emerge in the therapeutic relationship.

An holistic attempt to specify common elements in psychotherapy is presented by Hobbs (1962) and Vance and Volsky (1962). While Vance and Volsky have focused upon the common concerns of counseling and psychotherapy in "psychological discordance reduction" and psychopathology, Hobbs (1962, p. 741) has presented his theories of the sources of "gain" in counseling as:

1. In the therapeutic relationship the client has a sustained experience.
2. The client has opportunities to divest verbal and other symbols of their anxiety-producing potential.
3. The client has opportunities to learn that it is possible to establish a simple, honest, open relationship with another person.
4. The laws of control of the situation are in the client, so that he has many opportunities for decision-making, assuming responsibility and developing a self-concept incorporating a great degree of competence.
5. The client has opportunities to clarify an old or learn a new cosmology for ordering his world.

Clearly, the interpersonal relationship is again prominent, and the elements in general are involved with the re-educative process in counseling.

The preceding attempts at formulating common elements in the psychotherapeutic process are characterized by their focus upon the therapeutic relationship and its facilitation of the re-learning process. While Rogers concerns himself primarily with the therapist-offered conditions facilitating therapeutic change, Harper, Hobbs, and Vance and Volsky concentrate on commonalities of the therapeutic process and describe the effectiveness of the relationship in terms of altering the client's sensory or response systems so that healthy behavior will occur in situations where unhealthy behavior has been dominant.

In an attempt to reconcile the "tough-" and "tender-minded" views of counseling and psychotherapy Truax and

Carkhuff (1963) point out that conditions focusing upon the interpersonal relationship between client and counselor seem to be common elements among the varied schools. They also call attention to the fact that, "...the tough-minded learning theory approach does not require that the therapist be merely an impersonal programmed reinforcement machine, while just as clearly the tender-minded view of therapy does not require that the therapist deny his role as providing a particular kind of stimulus complex to elicit and control the patient's behavior" (Truax & Carkhuff, 1963, p. 15). In summary, they conclude that"...the view of the therapeutic relationship itself appears to be a critical distinguishing factor between the tough- and tender-minded approaches to psychotherapy...and that many of the other divergencies between theories seem to be a matter of preference for terminology" (Truax & Carkhuff, 1963, p. 17).

Thus it would seem possible, from the recurring trends in the various theories, to investigate certain variables in the psychotherapeutic process which not only find theoretical support from a large variety of sources, but also would provide results which would be both meaningful and useful to counselors employing a variety of theoretical approaches.

The variables thus far identified in the literature can be summarized in two classes as follows:

1. Variables focusing upon the therapist
    a. Therapist accurate empathy
    b. Therapist unconditional positive regard
    c. Therapist genuineness, self-congruence or transparency
    d. Therapist intensity and intimacy of relationship
    e. Therapist concreteness
    f. Therapist personality
2. Variables focusing upon the patient-client
    a. Client's depth of interpersonal exploration
    b. Client's "likeability"

c. Degree of client's self-disturbance minus his degree of overt disturbance

Variables to be Studied

Since all of the preceding variables could not be investigated in the present study, several were chosen on the basis of their applicability to counseling practicum training and the volume and quality of substantiating research reports. The following four variables were selected:

1. Therapist accurate empathy
2. Therapist unconditional positive regard
3. Therapist self-congruence
4. Therapist intensity and intimacy of relationship

Since these variables seem to cut across theoretical boundaries, it would be best to describe briefly each before reviewing their supporting research.

Therapist Accurate Empathy. Accurate empathy on the part of the counselor or therapist involves both the sensitivity to current feelings and the verbal facility to communicate this understanding in a tone congruent with the client's current feelings. At a high level of empathy the message "I am with you" is unmistakably clear--the therapist's remarks fit with the patient's mood and content (Truax, 1961b). The therapist's responses not only indicate a sensitive understanding of the apparent feelings but seem to clarify and expand the client's awareness of his own feelings or experiences. This is communicated not only by the language appropriate to that of the client, but also by the total voice qualities which reflect the seriousness, the attentiveness and the depth of feeling. Accurate empathy includes an understanding of patterns of human feeling and experiencing so as to infer feelings present in the client which are only partially implied. At a low level of empathy the therapist may be preoccupied with his own intellectual interpretations and be scarcely aware of the client's "being." The therapist at this low level of empathy may hold his focus of attention upon the content of what the client says rather than upon what the client feels or "is" during that moment and thus may ignore, misunderstand, or simply fail to sense the client's current feelings and experiencings. In light of this, the therapist may be accurately describing psychodynamics to the client but lack of empathy would be indicated by such a description being in a language not that of the client or by being presented at a time when these dynamics are far removed from the current feelings of the client (Truax, 1961b). The result is that the therapist is "pulling" the client along rather than being "with" the client in his self-exploration.

Therapist Unconditional Positive Regard. Unconditional positive regard for the client refers to an acceptance of the client as a person with human potentialities. It involves a non-possessive caring for the client as a separate person, and thus a willingness to share equally the patient's joys and aspirations or his depressions and failures. It involves the valuing of the client as a person without contamination from evaluating his behavior or his thoughts (Truax, 1962e).

Therapist Genuineness or Self-Congruence. Genuineness or self-congruence of the counselor involves an honest openness to experiencing within the psychotherapeutic relationship. It means that within the therapeutic relationship there is no professional air, no facade, no deceit. It means that the counselor is not denying feelings of experiences within the relationship--that he does not hold himself aloof from a personal encounter because of a pretense of professionalism. He is being himself rather than denying himself (Truax, 1962d).

Intensity and Intimacy of Relationship. Intensity and intimacy of interpersonal contact by the therapist involves an intensity in voice and manner which has a compelling personal note. There is accentuated feeling tone, voice, and manner which is both deeply concerned and confidential. The counselor is preoccupied with the client and his experiencing or feelings and a heightened atmosphere is achieved by the counselor's "hovering attentiveness." There is a combination of alertness and absorption in the client by the counselor which communicates a vital concern. The voice combines both depth of feeling and solicitous closeness which communicates an accentuated feeling tone and a fervid concentration, a profound seriousness and sincerity. The entrancing quality is clear in voice and manner of the counselor (Truax, 1962b).

Research Concerning the Variables

A good deal of research using a variety of approaches has been carried out focusing upon the variables accurate empathy, unconditional positive regard and counselor self-congruence. Barrett-Lennard (1962) and Halkides (1958) investigated the importance of these three counselor characteristics with a university counseling center population. Their data indicated the relevance of these conditions for success with counseling cases. Early research by Truax (1961a) also indicated the relevance of these therapist-offered conditions to effective group psychotherapy with hospitalized mental patients.

Reports growing out of the Wisconsin program (Gendlin, 1961; Stoler, 1961; Tomlinson, 1961; Truax, 1961c) headed by Carl Rogers also focused essentially upon these three therapist characteristics. This series of studies was based upon a five-year research program in which a number of patients in intensive individual psychotherapy were compared with a matched control group. Findings indicated that: (1) patients receiving psychotherapy and those receiving control conditions showed little difference in the average constructive personality change; but that (2) patients whose therapists offered high levels of unconditional positive regard, self-congruence or genuineness, and accurate empathic understanding, showed significant positive personality and behavior change on a wide variety of indicators; and (3) patients whose therapists offered relatively low levels of these conditions during therapy exhibited significant deterioration in personality and behavior functions. The evidence from these studies strongly suggested that the three measured therapist characteristics were predictive of outcome and that the number of therapists offering relatively high levels of these conditions approximated the number offering relatively low levels of these conditions, so that the average therapy patient outcome was not markedly different from that seen in the control groups.

Bergin and Solomon (1963), using the Accurate Empathy Scale (Truax, 1961b) in following up the empathy research of earlier studies (Truax, 1961a; 1963a), presented evidence that empathy was also significantly related to the therapist's ability to produce positive change in outpatients seen by fourth-year post-graduate clinical psychologists who had been trained in psychoanalytic technique.

Lesser (1961) reported findings suggesting that the therapist's ability to accurately predict the degree of similarity between himself and his patient's Q sort was significantly and positively related to the patient's progress. This seemed to suggest again that the sensitive, empathic therapist who is able to accurately assess the patient and himself is most effective.

In other studies (Rogers, 1962; Truax & Carkhuff, 1963) the findings indicated that the three therapist characteristics of accurate empathy, unconditional positive regard, and genuineness or self-congruence were also related in individual psychotherapy to the depth of patient self-exploration, which in turn was related to the outcome indices.

Truax (1961a) reported that while therapist empathy, unconditional positive regard and self-congruence were each individually related to the criterion of successful outcome, the measurement of empathy was affected by the variance of unconditional positive regard. Thus the therapist brought to the therapy situation two separate and individual personal or attitudinal characteristics: an accurate and warm understanding of the patient and an honest openness to experiencing.

A third important finding was that self-incongruence on the part of the therapist clearly inhibited self-exploration, but beyond a minimal critical level additional degrees of therapist self-congruence were not related to increases in patient functioning. The data suggested that a lack of self-congruence inhibits self-exploration; thus the concern should be with eliminating in the therapist a conscious or unconscious facade or tendency to "play the role of therapist."

Another study aimed at the role of therapist unconditional positive regard and "warmth" was reported by the eclectically oriented researchers Strupp, Wallach, Wogan and Jenkins (1963). It found substantial correlations between the therapist's ratings of outcome of therapy and the patient's ratings of emotional-attitudinal variables relating to the quality of the therapeutic relationship, particularly to the therapist's feelings of warmth, liking and regard for the patient.

Further reports of research on therapist accurate empathy, unconditional positive regard, self-congruence or transparency, and intensity and intimacy of relationship have been made by the following: Cartwright and Learner (1963); Carkhuff (1963, 1967a, 1967b); Carkhuff and Truax (1963, 1965); Combs and Soper (1963); Dickenson and Truax (1965); Jourard (1959); Peres (1947); Rogers (1962); Seeman (1949); Teuber and Powers (1953); Truax (1961a, 1961b, 1961c, 1962a, 1962b, 1962c, 1962d, 1962e, 1963a, 1963b, 1965, 1966); Truax and Carkhuff (1963, 1964a, 1964b, 1964c, 1965); Truax, Carkhuff and Kodman (1965); Truax, Wargo, Frank, Imber, Battle, Hoen-Saric, Nash and Stone (1965b).

As this list is rather lengthy, several representative studies will be cited in detail:

In order to determine whether accurate empathy was related to therapeutic progress in the initial stages of psychotherapy, eight patients were selected from the total sample of patients in intensive psychotherapy who represented the extremes of improvement and deterioration in behavioral functioning and personality (Truax, 1961c). The four most improved and the four most deteriorated after six months of therapy were selected on the basis of a battery of psychological tests as well as ward behavior ratings kept by the hospital. Evaluations were based upon the behavioral and personality measures made before therapy and after six months of therapy. Every session was tape recorded, and for analysis, small samples of therapeutic interactions were randomly selected from the middle one-third of each of 384 recorded sessions. These were assigned code numbers so that raters would not know whether they came from a test-improved or a test-deteriorated case, or from an early or late interview. Previously trained raters were then given the 384 samples in random order, and asked to rate each on the Accurate Empathy Scale (Truax, 1961b). The findings indicated that psychotherapy with test-improved patients received consistently higher values on the Accurate Empathy Scale than the psychotherapy recorded with the test-deteriorated cases ($P > .01$). Also, very low ratings tended to occur primarily in the recordings from the test-deteriorated patients while very high values of accurate empathy occurred almost exclusively in the recordings of the test-improved group ($X^2p > .01$).

In a replication of this approach (Rogers, 1962), fourteen cases of hospitalized schizophrenics and fourteen counseling cases were obtained from the University of Chicago and Stanford University Counseling Services. The findings indicated that accurate empathy, unconditional positive regard and therapist self-congruence were significantly higher for successful cases than for less successful or failure cases ($X^2p > .01$), and these positive relationships between the theoretical ingredients and independent measures of personality change held for both hospitalized schizophrenics and for counseling clients.

In an attempt to study the effects of the therapist-offered conditions of accurate empathy and unconditional positive regard and the consequent patient engagement in intrapersonal exploration, the level of these conditions was experimentally manipulated during actual sessions. After establishing a level of patient depth of intrapersonal exploration during the first twenty minutes of an initial psychotherapeutic interview where relatively high therapeutic conditions were present, the therapists deliberately introduced lowered levels of the conditions and maintained that level for a twenty minute period. Finally, this was followed by a twenty minute period where the normally high conditions were re-established. The test of the hypothesis was simply an evaluation of the levels of patient depth of intrapersonal exploration to determine whether or not the lowered conditions indeed produced lowered levels of process in the patient.

In analysis it was found that the predicted consequent drop in patient depth of intrapersonal exploration occurred when conditions were lowered. The differences in patient depth of self-exploration predicted to occur as a consequence of lowered conditions of empathy and positive regard proved statistically significant using both analysis of variance ($P \geq .01$) and *t* tests ($P \geq .05$). The patient's level of process was found to return to its previous higher level when the higher level conditions were reinstated.

Practicum Training and Counselors' Self-Concepts

The work of Walz and Johnson (1963) indicated that self-concept strength affected the use of a counselor training device in that counselors who showed low self-concept strength (Bill's IAV score below the mean on either acceptance of self or acceptance of others) used more negative items to describe themselves after video tape viewing of their role playing than did those who were above the mean on the IAV.

Hansen and Barker (1964) found indications that defensiveness on the part of the counselors influenced their "experiencing" (process scale) scores in that trainees who were defensive (low experiencing scores) reported a better relationship with their supervisors. This they assumed to be a "socially desirable" report in contrast with the less defensive counselors who were more accurate and objective in their evaluations of their relationships with supervisors.

Webb and Harris (1963) studied changes of self-perception of NDEA Institute members using a semantic differential technique. Significant positive self-concept changes were found in the areas of "actual self" and "ideal self."

Summary

In summary, a review of the related literature has produced the following significant findings:

1. Counselors' evaluations have been found to be valid, reliable and, in one case, predictive of future counseling success.
2. The variables of the psychotherapeutic encounter which will be studied have wide applicability in terms of the various theoretical orientations.
3. The four counselor-offered conditions are significantly linked with counselor success.
4. Counselors' self-concepts can be affected by certain training procedures, and defensiveness can influence the counselors' reaction to certain instruments.

CHAPTER III

Instruments for Data Collection

The Tennessee Self Concept Scale

The Tennessee Self Concept Scale (TSCS) consists of one hundred self-descriptive statements which attempt to elicit the subject's own picture of himself. Each item is rated by the subject on a five-point scale as to the extent to which the item is descriptive of himself.

The underlying rationale is based upon clinical and research findings which indicate that the individual's concept of himself has great influence upon his behavior, general personality, and state of mental health. The test items were drawn from a large pool of items used by previous investigators (Balester, 1956; Engle, 1956; Taylor, 1953), from written descriptions of patients and non-patients, and from the Minnesota Multiphasic Personality Inventory (MMPI). These items are non-offensive in nature.

The TSCS is available in two forms: a Counseling Form which yields fifteen subscale scores and a Clinical and Research Form which yields thirty subscale scores. The Clinical and Research Form was used in the present study, and the specific subscales investigated were Total Positive (TP), Self Criticism (SC), Distribution (D), and Defensive Positive (DP). The author of the TSCS defines these subscales as follows:

> Total Positive (TP): This is the most important single score on the TSCS and reflects the overall level of self-esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed and unhappy; and have little faith or confidence in themselves (Fitts, 1965, p. 2).
>
> Self Criticism (SC): This scale is composed of ten items derived from the L-Scale of the MMPI. These are all mildly derogatory statements that most people admit as being true for them. Individuals

> who deny most of these statements most often are being defensive and making a deliberate effort to present a favorable picture of themselves. High scores generally indicate a normal, healthy openness and capacity for self-criticism. Extremely high scores (above the 99th percentile) indicate that the individual may be lacking in defenses and may in fact be pathologically undefended (Fitts, 1965, p. 2).
>
> Distribution (D): This score is a summary score of the way one distributes his answers across the five available choices in responding to the items of the Scale. It is also interpreted as a measure of still another aspect of self-perception: certainly about the way one sees himself. High scores indicate that the subject is very definite and certain in what he says about himself, while low scores mean just the opposite. Low scores are found also with people who are being defensive and guarded. They hedge and avoid really committing themselves by employing "3" responses on the Answer Sheet (Fitts, 1965, p. 3).
>
> Defensive Positive (DP): This is a more subtle measure of defensiveness than the SC Score. The DP Score stems from a basic hypothesis of self-theory: that individuals with established psychiatric difficulties do have negative self-concepts at some level of awareness, regardless of how positively they describe themselves on an instrument of this type. The DP Score has significance at both extremes. A high DP Score indicates a positive self-description stemming from defensive distortion. A significantly low DP Score means that the person is lacking in the usual defenses for maintaining even minimal self-esteem (Fitts, 1965, p. 5).

Reliability of the TSCS

The reliability coefficients of all major subscores reported by the test author (Fitts, 1965) with a test-retest procedure on sixty college students over a two-week period ranged from .67 to .92, with the self-concept subscores ranging from .80 to .92. The author also reports additional evidence of reliability in the similarity of profile patterns found on repeated measure of the same individuals over a long period of time (a year or more).

Validity of the TSCS

Four types of evidence are offered by the author for validity: (1) content validity, (3) discrimination between groups, (3) correlation with other measures, and (4) personality changes under particular conditions (Fitts, 1965).

Content validity. The original pool of items was judged by seven clinical psychologists and only items on which there was unanimous agreement were retained.

Discrimination between groups. The TSCS was found to discriminate between patients and non-patients at the .001 level of significance on all scales except Self Criticism (SC), Column Total V (CT-V), Distribution (D) and Number 1 Responses (R_1) ($N = 995$). These scales do discriminate, however, between more specific diagnostic categories within the patient group (Congdon, 1958; Fitts, 1965; Havener, 1961; Piety, 1958; Wayne, 1963). Cross-validation was performed on eight matched groups of one hundred persons each.

The TSCS was also found to discriminate persons at the high extreme of the psychological health continuum. The subjects in this case were persons of judged high personality integration.

The subscales SC, CT-V, D, and R_1 were found to discriminate such groups as paranoid schizophrenics, depressive reactions, emotionally unstable personalities and juvenile offenders (Atchison, 1958, Lefeber, 1964).

Correlation with other measures. Correlations between the TSCS and the MMPI scores of 102 psychiatric patients are acceptable with the exceptions of the Variability Scores, Distribution Scores and Conflict Scores, which show little linear correlation. This is consistent with Fitts' (1965, p. 24) predictions that disturbed persons would show extreme scores in both the high and low directions.

Data from sixty-six high school students indicate little correlation between the TSCS and the Edwards Personal Preference Schedule.

Personality changes under particular conditions. The Manual for the TSCS (Fitts, 1965) reports several unpublished studies employing the Scale in a variety of settings. Studies indicated that the TSCS was valuable for predicting change in psychotherapy.

The Psychotherapeutic Interaction Scales

The four Psychotherapeutic Interaction Scales which were used in this study were developed by Charles B. Truax at the University of Wisconsin Psychiatric Institute and were published as mimeographed research reports (Truax, 1961b, 1962a, 1962b, 1962d). The variables allegedly measured have been identified by a number of workers representing various theoretical orientations (see Chapter II).

Reliability

The Scales have been used in a number of investigations and rater reliability was established in each. Since the process for establishing reliability was virtually the same in all cases, the results will be summarized below:

Reference	Reliability Reported	Nature of Judges
Truax (1961)	.84* to .96*	Mixed professional & non-professional
Truax (1962)	.70* to .82*	Medical
Truax (1962)	.70* to .80*	Professional
Carkhuff & Truax (1963)	.70* to .80*	Professional
Truax & Carkhuff (1963)	.68 to .83	Professional
Carkhuff & Truax (1965)	.70 to .80	Naive undergraduates
Truax, et al. (1965a)	.59 to .60	Exp. & naive raters
Truax & Carkhuff (1965)	.68* to .83*	Professional
Truax (1966)	.84* to .95*	Professional

*Intraclass correlations (Ebel, 1951)

Validity

The literature pertaining to the validity of the scales is abundant (Carkhuff, 1967a; Carkhuff & Truax, 1963; Truax, 1961a, 1962a, 1962b, 1963a, 1963b, 1965, 1966; Truax & Carkhuff, 1963, 1965; Truax, et al., 1965). Several representative studies will be cited below:

In a blind analysis of change in level of psychological functioning, clinical psychologists were given results of a test battery (Rorschach Diagnostic Test, MMPI, TAT, WAIS, Anxiety Reaction Scales, Stroop Tests, F-Authoritarian Scale, Q-Sort and Whittenbaum Psychiatric Rating Scale) which had been administered to both experimental and control groups receiving "high conditions" and "low conditions" therapy as judged by the Scales. Results indicated that patients receiving high levels of conditions, as measured by the Scales, showed overall gain in psychological functioning, whereas those who received low levels of the variables showed a loss in functioning.

In several other studies in which the therapeutic conditions were experimentally manipulated during the course of the interview (twenty minutes of "high conditions," twenty minutes of "low conditions" and finally twenty minutes of "high conditions"), there were significant corresponding highs and lows on a Process Scale and in the degree of intrapersonal exploration (Truax & Carkhuff, 1963, 1965).

It should be noted at this point that the variables measured by these Scales may not be "necessary and sufficient" conditions for therapeutic change in counseling (Rogers, 1957). The factor loadings or beta weights associated with each variable are unknown, and there is no assurance that there are not additional conditions which may, for some therapists, clients, and situations, singularly or with interactions, operate to facilitate or even retard the effects of these variables (Carkhuff, 1963). The scope of use and reference to these variables by theorists of various theoretical orientations seems, however, to insure at least a minimal degree of confidence that they form an integral part of the helping relationship.

Evaluation Record Forms

In order to facilitate the making and recording of evaluations and self-evaluation, appropriate record forms were constructed (see Appendix,pp. 75,76). These forms consist of schematic representations of the Scales on which each stage is accompanied by a short description. These short descriptions were composed from key words or phrases drawn from the full descriptions of the Scale stages, (Truax, 1961c, 1962c, 1962d, 1962e) and are meant to be used by the evaluator only as aids in remembering the significant features of each stage on the Scales. Thus the actual criteria for evaluation are the Scales themselves and not the abbreviations found on the record forms.

Accurate Empathy Schematic

The Accurate Empathy Schematic (Appendix, p. 77) was employed as an aid in understanding the AE Scale. The Schematic was supplied to both counselors and practicum instructors during the five-hour initial training period. Each person was instructed to use the Schematic to help clarify the Scale descriptions.

CHAPTER IV

Procedures for Conducting the Study

The Research Design

The central theme of this investigation was to implement a method of concrete, formalized counselor self-evaluation and to study its value as a method of counselor education within the counseling practicum.

The experimental design follows the Pretest-Posttest Control Group Design described by Campbell and Stanley (1966). Subjects were matched or "blocked" as an adjunct to randomization, and then randomly assigned to the experimental group with the matchmate being placed in the control group.

Population and Sample

Three counseling practicum classes at the University of Georgia were selected for the present study. The total enrollment in these three classes was fifty-two persons. The students' professional affiliations were as follows:

1. Counseling and Personnel Services (N = 25)
2. Rehabilitation Counseling (N = 24)
3. Employment Service Counseling (N = 1)
4. Dean of Students (N = 2)

The Personal Data Questionnaire (see Appendix, p. 78) was administered to the three practicum classes. A forty-four person sample was then selected and divided into two groups. Each member of Group I was matched with a member of Group II on the basis of age, sex, marital status, teaching experience, counseling experience, non-educational experiences and level of training in counseling. One subject in Group II withdrew due to illness during the term. Thus the final sample used for analysis consisted of forty-three subjects.

Training of Evaluators

Eight counseling practicum instructors were given five hours instruction on the nature and use of the four Psychotherapeutic Interaction Scales. The rationale behind the

Scales was discussed and numerous examples of recorded counseling sessions were evaluated and discussed by the instructors. The instructors then proceeded to evaluate a Training Tape consisting of sixteen segments drawn from four counseling sessions. Each of the sixteen segments was given one evaluation on each of the four Scales. The same eight counseling practicum instructors were asked to evaluate the same Training Tape once again approximately one month later.

The resulting 256 evaluations were analyzed by a method of estimation of the reliability of ratings proposed by Ebel (1951). The results were as follows:

TABLE 1

Average Reliability of Instructor Evaluations of Training Tape

Scale	Ebel Coefficient
AE	.88
IC	.90
UPR	.89
SC	.86

Procedure

Each member of the forty-four person sample was assigned a six-digit code number obtained from a table of random numbers. This code number was to be used on all forms and tests associated with the study, and the subjects were assured that the test results and/or the evaluations would remain anonymous and would not affect their course grade. The subjects were then pretested with the TSCS. The entire sample was then given five hours instruction on the nature and use of the Scales. The subjects were encouraged to ask any questions they wished pertaining to the Scales, and numerous recorded counseling sessions were evaluated for practice. The entire sample was given training sessions in order to minimize the effects of differential treatment between experimental and control subjects. The forty-four subjects were then divided into two matched groups. Both groups: (1) were pursuing degrees in counseling; (2) received counseling practicum training simultaneously; (3) received five hours instruction on the nature and use of the Scales; (4) were given equal opportunity to practice making evaluations; (5) were matched subject-by-subject on a number of factors; (6) were pretested with the TSCS; and (7) were supervised by the same instructors. Group I used the self-evaluation method, while Group II did not.

The counselors of Group I were instructed to evaluate their own counseling immediately after each live counseling session, considering the session as a whole in retrospect.

At the practicum supervision meeting, the counselor presented to the practicum supervisor the tape recorded counseling session together with the evaluation form for that session. The practicum supervisors were instructed neither to look at the counselor's self-evaluations nor to discuss the evaluations.

During the course of the supervision meeting, the instructor evaluated four segments of the tape, each of which was at least four minutes in length. These tape segments were chosen consecutively from beginning to end of the tape and were irregularly spaced. Each of the tape segments was evaluated with each of the four Scales; UPR, AE, IC and SC (see Appendix, pp. 68-74), giving each tape four evaluations per Scale or a total of sixteen evaluations per tape.

The members of Group II did not self-evaluate their counseling sessions. During the practicum supervision meeting, the supervisors evaluated the Group II tapes according to the procedure used with Group I.

Pilot Study

A preliminary study was conducted employing the Scales and the Evaluation Forms. The subjects of this study consisted of one entire counseling practicum class. No control group was used and no attempt was made to stratify, match, or in any other way be selective in obtaining subjects.

During the pilot study several variations in the procedure were experimented with. These consisted of:

1. discussing evaluations of the class members' tape recorded counseling sessions;
2. having the counseling student's tape evaluated by the entire class and discussing the peer evaluations; and
3. obtaining multiple instructor evaluations on the same taped sessions.

As a result of the pilot study, certain decisions were made concerning the procedure:

1. Wording on the Evaluation and Self-Evaluation forms was modified slightly to clarify significant differences between Scale stages.
2. Each subject was assigned a code number to insure the subject's anonymity, thus making free and honest responses more likely to occur.
3. More intensive training was given on the nature and use of the Scales, and more practice evaluations were made by the subjects.
4. Both experimental and control groups were given instruction on the Scales simultaneously in order to avoid the effects of differential treatment.

Analysis of Data

Since the data yielded by the Scales are ordinal in nature, the decision was made to use distribtuion-free or nonparametric statistical methods for analysis. The following statistics were employed (reference for all tests is Siegel, 1956):

Kolmogorov-Smirnov Two-Sample Test: (K-S Two-Sample Test).

The K-S Two-Sample Test is used to determine whether two independent samples have been drawn from the same population or populations with identical distributions. The one-tailed test determines whether the population values for one sample are stochastically larger (more random) than for the second. The two-tailed test is sensitive to any kind of difference in distribution (Siegel, 1956, p. 127).

In operation, the K-S Two-Sample Test focuses upon the differences between the two samples' cumulative distributions. The difference D is computed by the statistic:

$$D = \max\ [S_{n_1}(X) - S_{n_2}(X)]$$

for the one-tailed test, and

$$D = \max\ |S_{n_1}(X) - S_{n_2}(X)|$$

for the two-tailed test where: $S_{n_1}(X)$ = the observed cumulative step function of one sample, and $S_{n_2}(X)$ = the observed cumulative step function of the second.

When n_1 and n_2 are large ($\geq$ 40), the sampling distribution approximates the Chi-square distribtuion with df = 2, and the significance of D may be computed according to the statistic:

$$X^2 = 4D^2 \frac{n_1 n_2}{n_1 + n_2} .$$

Siegel (1956, p. 136) reports that the power-efficiency of the K-S Two-Sample Test is approximately 96 per cent for small samples, with a slight decrease in power-efficiency with increasing sample size.

Sign Test

The Sign Test is applicable to the case of two related samples. The only assumption in this case is that the variable studied has a continuous distribution. In practice, it focuses upon the direction of difference between the two samples (indicated by a +, - or 0 sign).

For small samples ($N \leq 25$) probability is determined by means of the binomial expansion. The one-tailed test is used to accept or reject the advanced prediction as to which sign,

+ or -, will occur more frequently. The two-tailed test is used to accept or reject the advanced prediction that there will be a significant difference in the frequency of + and - signs.

The power-efficiency of the Sign Test is approximately 95 per cent for N = 6, but decreases to a minimum of 63 per cent with increasing sample size (Siegel, 1956, p. 75).

Contingency Coefficient C

The contingency coefficient is a measure of the correlation between two samples. No continuity or order is assumed. In practice, the data are arranged in a contingency table with any k X r categories. The discrepancy between expected and observed cell values is then computed according to the statistic:

$$X^2 = \sum_{i=1}^{r} \sum_{j=1}^{k} \frac{(O_{ij} - E_{ij})^2}{E_{ij}} .$$

A measure of correlation is then computed by means of:

$$\underline{C} = \sqrt{\frac{X^2}{n + X^2}} .$$

Testing the significance of C is somewhat complicated by the fact that the upper limits of C are functions of the number of categories. When k = r, the maximum C for two perfectly correlated variables is yielded by:

$$\underline{C}_{max} = \sqrt{\frac{k - 1}{k}} .$$

A corrected contingency coefficient $\underline{C_c}$ may be obtained by:

$$\underline{C_c} = \frac{\sqrt{\frac{k - 1}{k}}}{\underline{C}} .$$

This statistic yields a coefficient of correlation which is more comparable to such measures of correlation as the Pearson r or the Spearman r_s (McNemar, 1949, p. 182).

A second method of determining the significance of C is by means of the computed X^2, with df = (k - 1)(r - 1).

All computations for the study were performed on an electronic calculator with the exception of the Sign Tests, which were read directly from a table of probabilities for the binomial expansion.

CHAPTER V

Results

The present study represents an attempt to answer three questions: (1) Can counselors make valid self-evaluations of their counseling performance by means of the Scales?; (2) Is self-evaluation by this method a valuable counselor education device?; and (3) Do basic personality orientations such as self-concept strength and defensiveness affect a counselor's ability to evaluate his own counseling performance?

In this chapter the results relevant to each specific hypothesis will be discussed.

Value of the Self-Evaluation Method

Null Hypothesis 1:

> There is no significant difference between the mean supervisor evaluations of the tape recorded counseling sessions of Groups I and II for counseling sessions conducted during the first and last one-third of the practicum training.

To test for the significance of the direction of movement, i.e., improvement, retention of status-quo, or deterioration of counseling performance, a one-tailed Sign Test was employed. The advanced prediction in this case was that improvement in counseling would occur more frequently than deterioration.

Results were as follows:

TABLE 2

Sign Test for Significance of Improvement in Mean Supervisor Evaluations for Counseling Performance in First and Last One-Third of Counseling Practicum

GROUP I

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	15	68.18	5	22.72	2	9.09	.001
AE	19	86.36	2	9.09	1	4.54	.001
IC	13	59.09	8	36.36	1	4.54	.001
SC	14	63.63	7	31.81	1	4.54	.001

GROUP II

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	12	57.14	6	28.57	3	14.28	.018
AE	7	33.33	4	19.04	10	47.61	.315
IC	88	38.09	8	38.09	5	23.80	.291
SC	14	66.66	4	19.04	3	14.28	.006

The Kolmogorov-Smirnov (K-S) Two-Sample Test was then employed to determine if the mean supervisors' evaluations of counseling performance of Group I were stochastically smaller than that of Group II. Results were as follows:

TABLE 3

K-S Two-Sample Test of the Mean Supervisor Evaluations of Counseling Performance in First and Last One-Third of Counseling Practicum of Groups I and II

Scale	D	X^2	df
UPR	.1602	1.09	2
AE	.6298	17.05**	2
IC	.2102	1.87	2
SC	.1216	0.634	2

**Significant at .01 level

Value of Self-Evaluation Method with Non-Experienced and Experienced Counselors

As a subhypothesis, the investigator wished to determine if the amount of counseling experience on the part of the subjects was related to the amount of gain in counseling performance measured by the Scales. For purposes of analysis, Groups I and II were subdivided into two groups each. Experienced (e) Groups I_e (N = 11) and II_e (N = 10) were composed of subjects with one-half year or more of counseling experience while non-experienced (ne) Groups I_{ne} (N = 11) and II_{ne} (N = 11) were composed of subjects who had no counseling experience beyond practicum training.

To test for the significance of the direction of change in counseling performance, the one-tailed sign test was again employed. The advanced prediction was that improvement in counseling would occur more frequently than deterioration. Results were as follows:

TABLE 4

Sign Test for Significance of Improvement in Mean Supervisor Evaluations for Counseling Performance of Experienced Counselors in First and Last One-Third of Counseling Practicum

GROUP I_e

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	6	54.54	2	18.18	3	27.27	.254
AE	8	72.72	2	18.18	1	9.09	.020
IC	6	54.54	4	36.36	1	9.09	.062
SC	4	36.36	6	54.54	1	9.09	.188

GROUP II_e

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	3	30	3	30	4	40	.500
AE	3	30	3	30	4	40	.500
IC	3	30	5	50	2	20	.500
SC	6	60	3	30	1	10	.062

TABLE 5

Sign Test for Significance of Improvement in Mean Supervisor Evaluations for Counseling Performance of Non-Experienced Counselors in First and Last One-Third of Counseling Practicum

GROUP I_{ne}

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	10	90.90	1	9.09	0	0	.001
AE	9	81.81	2	18.18	0	0	.002
IC	8	72.72	3	27.27	0	0	.004
SC	10	90.90	1	9.09	0	0	.011

GROUP II_{ne}

Scale	Improved		Unchanged		Deteriorated		Exact P: Significance of Improvement
	N	%	N	%	N	%	
UPR	8	72.72	2	18.18	1	9.09	.020
AE	4	36.36	1	9.09	6	54.54	.377
IC	5	45.45	3	27.27	3	27.27	.363
SC	8	72.72	1	9.09	2	18.18	.055

The K-S Two-Sample Test was then employed to detect differences in the distribution from which the two samples were drawn. Results were as follows:

TABLE 6

K-S Two-Sample Test of the Mean Supervisor Evaluations of Counseling Performance in First and Last One-Third of Counseling Practicum of Groups I_{ne} and II_{ne}

Scale	D	X^2	df
UPR	.2828	1.76	2
AE	.6363	8.80*	2
IC	.2727	1.56	2
SC	.3636	2.86	2

*Significant at .05 level

TABLE 7

K-S Two-Sample Test of the Mean Supervisor Evaluations of Counseling Performance in First and Last One-Third of Counseling Practicum of Groups I_e and II_e

Scale	D	X^2	df
UPR	.2637	1.40	2
AE	.4773	4.68	2
IC	.2455	1.40	2
SC	.2363	1.25	2

Concurrent Validity of Self-Evaluations

Null Hypothesis 2:

> There is no positive correlation between the counselors' self-evaluations of their performance in live counseling sessions and their supervisors' evaluations of tape recordings of the same counseling sessions.

To test the concurrent validity of the counselors' self-evaluations of live counseling sessions, self-evaluations were compared with supervisors' evaluations of the tape recording of the counseling session which had been evaluated live and in retrospect by the counselor. The extent of relationship between the two sets of evaluations was determined by constructing a contingency table and computing coefficients of contingency C. Results were as follows:

TABLE 8

Contingency Coefficients C for the Relationship Between Counselor's Self-Evaluation and Supervisor's Evaluations of Counseling Performance During the Entire Counseling Practicum

Scale	X^2	df	C	Maximum Possible C	C_c
UPR	57.67***	4	.506	.816	.620
AE	55.66***	4	.502	.816	.615
IC	41.68***	1	.444	.707	.628
SC	100.28***	4	.613	.816	.751

***Significant beyond the .001 level

Counselor Self-Concept Strength and Accuracy of Self-Evaluation

Null Hypothesis 3:

> The counselor's strength of self-concept, as measured by pretesting with the Tennessee Self Concept Scale, does not show a positive correlation

with his accuracy of self-evaluation of counseling performance (as determined by counselor/supervisor agreement on evaluations).

For purposes of analysis, the subjects of Group I were assigned rank orders based on their measured strength of self-concept as indicated by their Total P score on the TSCS. Groups representing high self-concept strength and low self-concept strength were then obtained by selecting the subjects whose Total P scores ranked them in the highest one-third (N = 7) and lowest one-third (N = 6) of Group I.

Two contingency tables were then prepared and the counselor/supervisor evaluations were plotted for both the high self-concept group and the low self-concept group. Each cell frequency was removed from the contingency tables according to a prearranged program. The order of removal of each cell frequency had the effect of constructing a step-frequency distribution ranging from the least accurate evaluation (e.g., counselor self-evaluates stage 1 while supervisor evaluates stage 5 or vice versa) to the most highly accurate evaluations (e.g., counselor self-evaluates stage 5 while supervisor also evaluates stage 5). The two step-frequencies were then analyzed by means of the K-S Two-Sample Test. Results were as follows:

TABLE 9

K-S Two-Sample Test of the Accuracy of Self-Evaluation of High Self-Concept Strength and Low Self-Concept Strength Groups

Scale	N Evaluations/ Self-Evaluations	D	X^2	df
UPR	107	.1110	1.24	2
AE	107	.1934	3.83	2
IC	107	.1927	0.88	2
SC	107	.0931	3.83	2

Counselor Defensiveness and Accuracy of Self-Evaluation

Null Hypothesis 4:

> The counselor's degree of defensiveness as measured by pretesting with the TSCS does not show a positive correlation with his accuracy of self-evaluation of counseling performance (as determined by counselor/supervisor agreement on evaluations).

Analysis of data for Null Hypothesis 4 was performed according to the same procedure used in testing Null Hypothesis 3. The subjects of Group I were assigned rank orders based upon three subscales of the TSCS measuring defensiveness: Defensive Positive (DP); Distribution (D); and Self Criticism (SC). Subjects in the highest one-third and lowest one-third of Group I on each of these subscales were selected.

Contingency tables were then prepared and the counselor/supervisor evaluations were plotted for both the high one-third and low one-third groups. The cell distributions of these contingency tables were then analyzed by means of the K-S Two-Sample Test. Results were as follows:

TABLE 10

K-S Two-Sample Test of the Accuracy of Self-Evaluation of High DP and Low DP Groups

Scale	N Evaluations/ Self-Evaluations	D	X^2	df
UPR	105	.1760	3.18	2
AE	105	.2402	1.00	2
IC	105	.0986	2.21	2
SC	105	.1570	5.94	2

TABLE 11

K-S Two-Sample Test of the Accuracy of Self-Evaluation of High D and Low D Groups

Scale	N Evaluations/ Self-Evaluations	D	X^2	df
UPR	114	.0385	0.35	2
AE	114	.1186	1.78	2
IC	114	.1371	2.14	2
SC	114	.1670	4.42	2

TABLE 12

K-S Two-Sample Test of the Accuracy of Self-Evaluation of High SC and Low SC Groups

Scale	N Evaluations/ Self-Evaluations	D	X^2	df
UPR	105	.2358	5.49	2
AE	105	.2408	5.65	2
IC	105	.4583	20.16***	2
SC	105	.1878	3.46	2

***Significant beyond .001 level

CHAPTER VI

Summary and Implications

Problem

Purpose and Objectives

The problem of this study was to investigate the value of a method of counselor self-evaluation as a counselor education device. The prime objective was to determine the effect on the measured counseling performance of counselors who made use of a method of concrete, formalized and immediate feedback and self-evaluation. Secondary objectives were to: (1) determine the validity of four Psychotherapeutic Interaction Scales when used for self-evaluation of counseling performance by counselors, (2) investigate the relationship between the counselors' strength of self-concept and accuracy of self-evaluation; and (3) investigate the relationship between the counselors' degree of defensiveness and accuracy of self-evaluation.

Significance

Leaders in the field of counselor education have stressed two main points of concern: (1) the counselor should develop the ability to examine, criticize and improve upon his own counseling performance (Boy & Pine, 1966; Dreikurs & Sonstegard, 1966; Hansen, 1965; Hansen & Moore, 1966; Patterson, 1964; Peters, 1963; Truax, 1965, Truax, Carkhuff, & Douds, 1964); and (2) the counselor should receive immediate and concrete feedback on his performance (Carkhuff & Truax, 1965; Dreikurs & Sonstegard, 1966; Miller & Oetting, 1966; Truax, 1964; Truax, Carkhuff, & Douds, 1964).

The need for a method of counselor self-evaluation extends beyond the training program. Customarily the in-service supervision of counselors is conducted through staff meetings, review of tape recorded counseling sessions and consultation with available counselor educators (Boy & Pine, 1966; Hansen & Moore, 1966). There are many instances, however, when counselor supervision is impractical or impossible. In some college and university counseling centers, for example, the staff size and counseling load limit supervision, and some elementary and secondary schools are too isolated for easy consultation and supervision. Thus, self-evaluation is needed to enable counselors to evaluate their own efforts, and such a system should facilitate personal and professional growth.

Related Research

The literature pertaining to this study was reviewed under the categories of: (1) self-evaluation techniques; (2) psychotherapeutic variables studied; and (3) effects of practicum training and counselor's self-concepts. The following major points were brought out:

1. Counselors' evaluations have been found to be valid, reliable and, in one case, predictive of future counseling success.
2. The variables of the psychotherapeutic encounter which were studied appear in the writings of psychoanalytic, client-centered, and eclectic theorists and appear to have wide applicability in terms of the various theoretical orientations.
3. The four counselor-offered conditions have been linked significantly with counseling success.
4. Counselors' self-concept strength can be affected by certain training procedures, and defensiveness on the part of the counselor can influence his reaction to certain instruments.

Method

Experimental Design

The experimental design follows the Pretest-Posttest Control Group Design described by Campbell and Stanley (1966). Subjects were blocked as an adjunct to randomization, and then randomly assigned to the experimental group with the matchmate being placed in the control group.

Population and Sample

A forty-four person sample was selected from three counseling practicum classes at the University of Georgia. The number of subjects actually used for final analysis was forty-three. The sample was then divided into two groups: Group I, which used the self-evaluation method; and Group II, which did not. Each member of Group I was matched with a member of Group II on basis of age, sex, marital status, teaching experience, counseling experience, non-educational experiences and level of training in counseling.

Both Group I and Group II subjects: (1) were pursuing degrees in counseling; (2) received five hours instruction on the nature and use of the Scales; (3) received counseling practicum training simultaneously; (4) were given equal opportunity to practice making evaluations; (5) were matched subject-by-subject on a number of factors; (6) were pretested with the TSCS; and (7) were supervised by the same instructors.

Procedures

Eight counseling practicum instructors were given five hours instruction on the nature and use of the Scales. Reliabilities of instructor evaluations were then computed and found to be satisfactory.

Each subject was assigned a six-digit code number to be used on all forms and tests. Subjects were further assured that test results and evaluations would remain anonymous and would not affect their course grades. The subjects were then asked to complete the Personal Data Questionnaire, and a forty-four person sample was selected. The entire sample was then pretested with the TSCS and given five hours training on the nature and use of the Scales.

During the counseling practicum, the counselors of Group I were instructed to evaluate their own counseling immediately after each live counseling session, considering the session as a whole in retrospect.

At the practicum supervision meeting, the counselor presented to the practicum supervisor the tape recorded counseling session, together with the evaluation form for that session. The practicum supervisors were instructed neither to look at the counselor's self-evaluations nor to discuss the evaluations.

During the supervision meeting, the instructor evaluated four segments of the tape, each of which was at least four minutes in length and chosen consecutively from the beginning at irregular intervals. Each of the tape segments was evaluated with each of the four Scales; UPR, AE, IC and SC, giving each tape four evaluations per scale or a total of sixteen evaluations per tape.

The subjects of Group II did not self-evaluate their counseling sessions. During the practicum supervision meeting, the supervisors evaluated the Group II tapes according to the procedure used with Group I.

Analysis

Since the data yielded by the instrucments were ordinal in nature, it was decided that appropriate non-parametric statistical methods would be employed.

Results

Analysis by means of the Sign Test indicated that Group I, which used the self-evaluation method, made significant improvement on all four Scale variables, while Group II, which did not use the self-evaluation method, made significant improvement on only two of the Scales (UPR and SC).

When the amount of gain made by Groups I and II was compared, the Kolmogorov-Smirnov Two-Sample Test indicated significantly greater gain for Group I on only one Scale, AE. The results were similar when experienced and non-experienced counselors from Groups I and II were compared. Non-experienced members of Group I made significantly greater gains over non-experienced members of Group II on only one Scale, AE.

Experienced members of Groups I and II showed no significant difference in gain on any of the four Scales.

Corrected contingency coefficients, $\underline{C}_c$, were calculated as measures of correlation between counselor's self-evaluations and their supervisor's evaluations of tape recorded sessions. Chi squares for each of the four Scales were significant beyond the .001 level, and the corrected contingency coefficients, $\underline{C}_c$, ranged from .615 to .751.

The Kolmogorov-Smirnov Test indicated no positive relationship between counselor's strength of self-concept (Total P subscale on the TSCS) and accuracy of counselor self-evaluation.

Similarly, the Kolmogorov-Smirnov Test indicated no positive relationship between measures of counselor defensiveness (TSCS subscales: D, DP, & SC) and accuracy of counselor self-evaluation, with but one exception. The high Self Criticism group achieved significantly higher stages ($P \geq .001$) of Intensity and Intimacy of Interpersonal Contact (IC) with their clients than did the low Self Criticism group.

Conclusions and Implications

The prime objective of this study was to investigate the value of a counselor education procedure utilizing four Psychotherapeutic Interaction Scales. Results indicate that while the counselors in this study who used these Scales for self-evaluation did make significant gains in their ability to offer high therapeutic conditions, their gains were not significantly greater than the counselors who receive traditional counseling practicum training. The one exception to this is the counselor-offered condition of empathy. Counselors who used the Scales for self-evaluation made significantly greater gain in their ability to offer high levels of empathy than did counselors who did not self-evaluate. Inexperienced counselors, in particular, seemed to benefit significantly from the self-evaluation approach to counseling supervision.

The one secondary hypothesis which yielded the most meaningful results was that dealing with the validity of counselors' self-evaluations. Results indicated that counselor self-evaluations on the Scales had highly significant concurrent validity when compared to supervisor evaluations. This would seem to indicate that self-evaluation by this method might be of value for counselors who could not obtain field supervision. The effect of the absence of the counselor/supervisor relationship is, of course, not known.

Attempts to correlate gross personality orientations such as self-concept strength and defensiveness with accuracy of self-evaluation were, on the whole, unproductive. Results did indicate, however, that persons who tended to be more self-critical (SC subscale on the TSCS) were significantly more able to achieve higher levels of Intensity and Intimacy of Interpersonal Contact (IC) with their clients. This would seem predictable in that persons who score high on the SC subscale tend to more freely admit to items of a mildly derogatory nature. A willingness to admit such faults might tend to encourage many clients to freely talk of their own shortcomings.

Implications for Further Research

As is the case with most research, the present study suggested several promising areas for study. Among these are:

1. The study might well be replicated with the addition of several recent psychotherapeutic interaction scales such as: Transparency; Depth of Intrapersonal Exploration; Concreteness; and Persuasive Potency.
2. In order to determine the most effective means of educating counselors, additional experimental groups might be used to study the effects of discussing evaluations with both the supervisors and the members of the practicum class.

3. The effect of the supervisor/counselor relationship on self-evaluations should be investigated.
4. Accuracy of self-evaluation should be investigated in terms of counseling outcome and other measures of counselor effectiveness.

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APPENDIX

TABLE 13

Mean Supervisor Evaluations of Counseling Performance During First One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I	$\overline{X}$ Group II
UPR	2.99	3.27
AE	4.11	4.56
SC	2.81	2.90
IC	3.25	3.25

TABLE 14

Mean Supervisor Evaluations of Counseling Performance During Last One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I	$\overline{X}$ Group II
UPR	3.44	3.44
AE	5.19	4.54
SC	3.40	3.41
IC	3.55	3.48

TABLE 15

Mean Supervisor Evaluations of Counseling Performance of Experienced Counselors During First-One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I	$\overline{X}$ Group II
UPR	3.09	3.25
AE	4.20	4.59
SC	2.98	2.99
IC	3.42	3.44

TABLE 16

Mean Supervisor Evaluations of Counseling Performance of Experienced Counselors During Last One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I_e	$\overline{X}$ Group II_e
UPR	3.30	3.36
AE	5.13	4.57
SC	3.39	3.47
IC	3.56	3.61

TABLE 17

Mean Supervisor Evaluations of Counseling
Performance of Non-Experienced Counselors
During First One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I_{ne}	$\overline{X}$ Group II_{ne}
UPR	2.87	2.81
AE	4.03	4.54
SC	2.60	2.83
IC	3.09	3.08

TABLE 18

Mean Supervisor Evaluations of Counseling Performance of Non-Experienced Counselors During Last One-Third of Counseling Practicum

Scale	$\overline{X}$ Group I_{ne}	$\overline{X}$ Group II_{ne}
UPR	3.71	3.43
AE	5.26	4.51
SC	3.41	3.36
IC	3.59	3.36

TABLE 19

Background Data on Sample

Subject	Age	Sex	Marital Status	Years Teach. Exp.	Years Couns. Exp.	Non-Ed. Years Work Exp.	Highest Degree Held	Professional Affiliation
1	25	F	S	3	2	0	MSEd	CG
2	35	M	M	3	3	10	MS	CG
3	52	F	S	0	5	27	BA	ESC
4	32	M	M	0	4	19	AB	VRC
5	38	F	M	16	5	0	MAEd	CG
6	22	M	S	0	1/2	0	AB	VRC
7	41	M	M	0	12	15	AB	CG
8	22	M	M	0	1/2	1	BA	VRC
9	35	M	S	0	1/2	11	BA	VRC
10	22	M	S	0	0	0	BA	VRC
11	41	M	M	0	8	16	BSBA	VRC
12	23	M	S	0	1/2	3	AB	VRC
13	30	F	S	6	0	0	AB	CG
14	23	M	M	0	0	0	AB	VRC
15	42	M	M	7	1/2	10	MEd	CG
16	33	F	M	0	0	14	MFA	CG
17	29	F	S	5	0	0	BS	CG
18	30	F	S	5	0	1	MEd	VRC
19	47	F	W	5 1/2	5	17	MSEd	DW
20	21	F	S	0	0	0	AB	CG
21	41	M	M	15	2	2	MEd	CG
22	42	M	M	22	1	3	MEd	CG
23	43	M	M	11	1	5	BSEd	CG
24	26	M	M	4	3	0	BS	CG
25	27	F	M	3	0	0	MAT	CG
26	28	F	M	3	0	5	BS	CG
27	39	F	M	17	6	0	MAEd	CG
28	37	F	S	17	0	8	AB	CG
29	32	F	S	7	0	2	BSHEc	CG
30	48	F	M	20	0	0	BSHEc	CG
31	63	F	W	24	0	9	MEd	CG
32	53	F	M	5	1/2	0	BA	CG
33	27	F	D	3	0	0	AB	VRC
34	31	F	S	5	0	1	MEd	VRC
35	42	M	M	0	0	15	BS	VRC
36	32	M	M	5	4	4	MEd	VRC
37	24	M	M	0	0	2	AB	VRC
38	26	M	S	1	0	4	BA	VRC
39	27	M	M	0	0	0	BA	VRC
40	22	M	S	0	0	0	AB	VRC
41	21	M	S	0	0	0	BS	VRC
42	22	M	S	0	0	1	BS	VRC
43	40	M	M	16	2	3	MEd	CG
44	24	F	S	0	0	0	BA	VRC

VRC = Vocational Rehabilitation Counseling
CG = Counseling and Guidance
ESC = Employment Service Counselor
DW = Dean of Women

A SCALE FOR THE MEASUREMENT
OF UNCONDITIONAL POSITIVE REGARD

Charles B. Truax, Ph.D.

Psychotherapy Research Section
Wisconsin Psychiatric Institute
University of Wisconsin
1962

Stage 1

The therapist is actively offering advice or giving clear negative regard. He may be telling the patient what would be "best" for him, or may be in other ways actively either approving or disapproving of his behavior. The therapist acts in such a way as to make himself the focus of evaluation. The therapist sees himself as responsible _for_ the patient.

Stage 2

The therapist responds mechanically to the client and thus indicates little positive regard and hence little unconditional positive regard. The therapist may ignore the patient or his feelings or display a lack of concern or interest for the patient. Therapist ignores client where an unconditional positive regard response would be expected--complete passivity that communicates almost unconditional lack of regard.

Stage 3

The therapist indicates a positive caring for the patient or client but it is a semi-possessive caring in the sense that he communicates to the client that what the client does or does not do, matters to him. That is, he communicates such things as "it is not all right if you act immorally," "I want you to get along at work," or "it's important to me that you get along with the ward staff." The therapist sees himself as responsible _for_ the client.

Stage 4

The therapist clearly communicates a very deep interest and concern for the welfare of the patient. The therapist communicates a nonevaluative and Unconditional Positive Regard to the client in almost all areas of his functioning. Thus, although there remains some conditionality in the more personally and private areas the patient is given freedom to be himself and to be liked as himself. Thus, evaluations of thoughts and behaviors are for the most part absent. In deeply personal areas, however, the therapist may be conditional so that he communicates to the client that the client may act in any way he wishes except that it is important to the therapist that he be more mature or that he not regress in therapy or the therapist himself is accepted and liked. In all other areas, however, Unconditional Positive Regard is communicated. The therapist sees himself as responsible _to_ the client.

Stage 5

At Stage 5, the therapist communicates Unconditional Positive Regard without restriction. There is a deep respect for the patient's worth as a person and his rights as a free individual. At this level the patient is free to be himself even if this means that he is regressing, being defensive, or even disliking or rejecting the therapist himself. At this stage the therapist cares deeply for the patient as a person but it does not matter to him in which way the patient may himself choose to behave. There is a caring for and a prizing of the patient for his human potentials. This genuine and deep caring is uncontaminated by evaluations of his behavior or his thoughts. There is a willingness to equally share the patient's joys and aspirations or his depressions and failures. The only channeling by the therapist may be the demand that the patient communicate personally relevant material.

A SCALE FOR THE MEASUREMENT OF ACCURATE EMPATHY

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Stage 1

Therapist seems completely unaware of even the most conspicuous of the client's feelings. His responses are not appropriate to the mood and content of the client's statements and there is no determinable quality of empathy, hence, no accuracy whatsoever. The therapist may be bored and disinterested or actively offering advice but he is not communicating an awareness of the client's current feelings.

Stage 2

Therapist shows a degree of accuracy which is almost negligible in his responses, and then only toward the client's most obvious feelings. Any emotions which are not so clearly defined, he tends to ignore altogether. He may be correctly sensitive to obvious feelings and yet misunderstand much of what the client is really trying to say. By his response he may block off or may misdirect the patient. Stage 2 is distinguishable from Stage 3 in that the therapist ignores feelings rather than displaying an inability to understand feelings.

Stage 3

Therapist often responds accurately to client's exposed feelings. He also displays concern for the deeper, more hidden feelings, which he seems to sense must be present, though he does not understand their nature. The therapist seems to assume the presence of deep feelings, although he does not sense their meaning to this particular patient.

Stage 4

Therapist usually responds accurately to the client's more obvious feelings and occasionally recognize some that are less apparent. In the process of this tentative probing, however, he may anticipate feelings which are not current to the client, as well as misinterpreting some present feelings. Sensitivity and awareness of the therapist are present but he is not entirely "with" the patient in the current situation or experience. The desire and effort to understand are both present but accuracy is low. It is distinguishable from Stage 2 in that the therapist does occasionally recognize feelings that are less apparent. Also the therapist may seem to have a theory about the patient and may even know how or why the patient feels a particular way, but the therapist is definitely not "with" the patient--they are not together. In short, the therapist may be diagnostically accurate, but not empathically accurate in his sensitivity to the current feeling state of the patient.

A SCALE FOR THE MEASUREMENT OF ACCURATE EMPATHY - continued

Stage 5

Therapist accurately responds to all of the client's more readily discernible feelings. He shows awareness of many feelings and experiences which are not so evident, too, but in these he tends to be somewhat inaccurate in his understanding. The therapist may recognize more feelings that are not so evident. When he does not understand completely this lack of complete understanding is communicated without an anticipatory or jarring note. His misunderstandings are not disruptive by their tentative nature. Sometimes in Stage 5 the therapist simply communicates his awareness of the problem of understanding another person's inner world. Stage 5 is the midpoint of the continuum of accurate empathy.

Stage 6

Therapist recognizes most of the client's present feelings, including those which are not readily apparent. Sometimes, however, he tends to misjudge the intensity of these veiled feelings, with the result that his responses are not always accurately suited to the exact mood of the client. In content, however, his understanding or recognition includes those not readily apparent. The therapist deals with feelings that are current with the patient. He deals directly with what the patient is currently experiencing although he may misjudge the intensity of less apparent feelings. Often the therapist, while sensing the feelings, is unable to communicate meaning to these feelings. The therapist statements contain an almost static quality in contrast to Stage 7 in the sense that the therapist handles those feelings that the patient offers but does not bring new elements to life. He is with the client but doesn't encourage exploration. His manner of communicating his understanding is such that he makes of it a finished thing.

Stage 7

Therapist responds accurately to most of the client's present feelings. He shows awareness of the precise intensity of most underlying emotions. However, his responses move only slightly beyond the area of the client's own awareness, so that feelings may be present which are not recognized by the client or therapist. The therapist moves on his own to more emotionally laden material. The therapist may communicate simply that the patient and he are moving towards more emotionally significant material. Stage 7 is distinguishable from Stage 6 in that often the therapist response is a kind of pointing of the finger toward emotionally significant material with great precision in the direction of pointing.

Stage 8

Therapist accurately interprets all the client's present, acknowledged feelings. He also uncovers the most deeply-shrouded of the client's feeling areas, voicing meanings in the client's experience of which the client is scarcely aware. Since he must necessarily utilize a method of trial and error in the new uncharted areas, there are resulting minor flaws in the accuracy of his understanding, but inaccuracies are held tentatively. He moves into feelings and experiences that are only hinted at by the client and does so with sensitivity and accuracy. The therapist offers specific explanations or additions to the patient's understanding so that not only are underlying emotions pointed to, but they are specifically talked about. The content that comes to life may be new but it is not alien. While the therapist in Stage 8 makes mistakes, mistakes do not have a jarring note, but are covered by the tentative character of the response. Also the therapist is sensitive to his mistakes and quickly alters or changes his response in midstream indicating that he more clearly knows what is being talked about and what is being sought after in the patient's own explorations. The therapist reflects a togetherness with the patient in tentative trial and error exploration. His voice tone reflects the seriousness and depth of his empathic grasp.

Stage 9

Therapist unerringly responds to the client's full range of feelings in their exact intensity. Without hesitation, he recognizes each emotional nuance and communicates an understanding of every deepest feeling. He is completely attuned to the client's shifting emotional content, he senses each of the client's feelings and reflects them in his words and voice. He explains the client's hint into a full-blown but tentative elaboration of feeling or experience with unerring sensitive accuracy. Both a precision in understanding and precision in the communication of this understanding are present. Both are expressed and experienced by the therapist without hesitancy.

AN APPROACH TO THE CONCEPTUALIZATION AND MEASUREMENT OF INTENSITY AND INTIMACY OF INTERPERSONAL CONTACT AS A VARIABLE IN PSYCHOTHERAPY

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Wisconsin Psychiatric Institute
University of Wisconsin

Stage 1

The therapist communicates a bored inattentiveness and indifference to the patient's communications or the patient's present "being". While the therapist may respond and carry on communications, he is clearly indifferent or inattentive to the patient and his current feeling process.

Stage 2

The therapist is disinterestedly attentive. It is clear that while the therapist is attentive he is not personally concerned with what the patient is saying or being. There is a remoteness or aloofness involved in the attentiveness of the therapist which clearly defines him as an outsider or a stranger.

Stage 3

The therapist is attentive and clearly concentrates on what the patient is saying or being. He is alert to the patient's communications and being but is not engrossed in the patient's process.

Stage 4

The therapist communicates a concerned attentiveness. The therapist is solicitous of the patient's feelings and experiences and communicates a deep concern. The voice qualities of the therapist carry an accentuated feeling tone and a closeness.

Stage 5

The therapist communicates a hovering attentiveness. The therapist is preoccupied with the patient's experiences and being and is vitally concerned. There is a note of deep concern and intimacy in the therapist's fervid attentiveness.

SCALE FOR THE MEASUREMENT OF THERAPIST GENUINENESS OR SELF CONGRUENCE

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Psychotherapy Research Group
Wisconsin Psychiatric Institute
University of Wisconsin

Stage 1

The therapist is clearly defensive in the interaction and there is explicit evidence of a very considerable discrepancy between his experiencing and his current verbalizations. Thus, the therapist may make striking contradictions in his statements or such contradictions may be obviously implicit in the content of what he says or his manner of saying. Or, the therapist may contradict the content of his verbalization with the voice qualities or non-verbal cues present (i.e., the upset therapist in a strained voice stating that he is "not bothered at all" by the patient's anger).

Stage 2

The therapist responds appropriately but in a professional rather than personal manner so that you get the impression that his responses are said because they sound good from a distance but do not express what the therapist really feels or means. There is a somewhat contrived or rehearsed quality or an air of professionalism present.

Stage 3

The therapist is implicitly either defensive or professional although there is no explicit evidence.

Stage 4

There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. There is self-congruence displayed by the therapist.

Stage 5

The therapist is freely and deeply himself in the relationship. There is an openness to experiences and feelings by the therapist of all types - both pleasant and hurtful - without traces of defensiveness or retreat into professionalism. There may be recognition of contradictory feelings but these are accepted or recognized. The therapist is clearly being himself in all of his responses whether these responses are personally meaningful or trite. At Stage 5 the therapist need not express personal feelings but it is clear that whether he is giving advice, reflecting, interpreting, or sharing experiences, that he is being very much himself so that his verbalizations match his inner experiences.

COUNSELING SELF-EVALUATION FORM*

Donald G. Martin
University of Georgia

____
Counselor

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Practicum Instructor

UNCONDITIONAL POSITIVE REGARD

1	Advice giving. Clear negative regard. Responsible for client.
2	Mechanical responses. Little positive regard. Ignores client &/or his feelings.
3	Positive caring for client. Semi-Possessive caring. Responsible for client.
4	Evaluation of thoughts & behavior absent. UPR present but some conditionality. Deep interest & concern. Responsible to client.
5	UPR Respect for client's worth. Client free to be self.

ACCURATE EMPATHY

1	Ignores obvious feelings. Inappropriate responses.
2	Accuracy negligible. Poor understanding of obvious feelings.
3	Usually responds accurately to obvious feelings. Doesn't understand veiled.
4	Accurate to obvious. Anticipates veiled feelings poorly.
5	Accurate to obvious. Sensitive but inaccurate to veiled feelings. Tentative interpretations.
6	Accurate to obvious & veiled. Doesn't recognize intensity. No forward movement.
7	Accurate to obvious & veiled & their intensity. Moves ahead on own.
8	Accurate to obvious & uncovers veiled feelings. Tentative explanations & explorations.
9	Flawless accuracy. Precision in understanding & communication of it..

INTENSITY & INTIMA
INTERPERSONAL CON

1	Bored inattentiven indifference. May respond & comm
2	Disinterestedly at Not personally con Aloofness.
3	Attentive, concent & alert. Not engrossed in c process.
4	Communicates conce attentiveness. Feeling tone of vo
5	Communicates hover attentiveness. Vitally concerned client's being.

*Scales Developed by C. B. Truax, Ph.D.
Wisconsin Psychiatric Institute

UNSELING SELF-EVALUATION FORM*
Donald G. Martin
University of Georgia

Interview No.__________

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		INTENSITY & INTIMACY OF INTERPERSONAL CONTACT		SELF CONGRUENCE
rately . iled.	1	Bored inattentiveness & indifference. May respond & communicate.	1	Counselor clearly defensive. Striking contradictions in counselor's statements.
elings	2	Disinterestedly attentive. Not personally concerned. Aloofness.	2	Responses appropriate but protected by professionalism. Responses "sound good" but have contrived or rehearsed quality.
rate . tions. & veiled. tensity.	3	Attentive, concentrating & alert. Not engrossed in client's process.	3	Counselor implicitly either defensive or professional.
& veiled	4	Communicates concerned attentiveness. Feeling tone of voice.	4	Neither implicit nor explicit evidence of defensiveness. No facade.
& un- ings. ns &	5	Communicates hovering attentiveness. Vitally concerned with client's being.	5	Counselor is freely & deeply himself. No defensiveness or professionalism.

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COUNSELING EVALUATI
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Practicum Instructor

UNCONDITIONAL POSITIVE REGARD

1 1 1 1	Advice giving. Clear neg. regard. Responsible for client.
2 2 2 2	Mechanical responses. Little positive regard. Ignores Client &/or his feelings.
3 3 3 3	Pos. caring for client. Semi-possessive caring. Responsible for client.
4 4 4 4	Eval. of thoughts & behavior absent. UPR present but some conditionality.
5 5 5 5	UPR Respect for client's worth. Client free to be self.

ACCURATE EMPATHY

1 1 1 1	Ignores client's feelings. Inappropriate responses.
2 2 2 2	Accuracy negligible. Poor understanding of obvious feelings.
3 3 3 3	Responds accurately to obvious feelings, but doesn't understand veiled feelings.
4 4 4 4	Accurate to obvious. Anticipates veiled poorly.
5 5 5 5	Accurate to obvious. Sensitive but inaccurate to veiled feelings. Tentative interpretations.
6 6 6 6	Accurate to obvious & veiled feelings. Doesn't recognize intensity. No forward movement.
7 7 7 7	Accurate to obvious & veiled feelings & their intensity. Counselor moves ahead on his own.
8 8 8 8	Accurate to obvious & veiled. Uncovers veiled feelings. Tentative explanations & explorations.
9 9 9 9	Flawless accuracy. Precision in understanding & communication of it.

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*Scales Developed by C. B. Truax, Ph.D.
Wisconsin Psychiatric Institute

COUNSELING EVALUATION FORM*
Donald G. Martin
University of Georgia

Interview No.____________

Date____________________

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INTENSITY & INTIMACY OF INTERPERSONAL CONTACT

1 1 1 1	Bored inattentiveness & indifference. May respond & communicate.
2 2 2 2	Disinterestedly attentive. Not personally concerned. Aloofness.
3 3 3 3	Attentive, concentrating and alert. Not engrossed in client's process.
4 4 4 4	Communicates concerned attentiveness. Feeling tone of voice.
5 5 5 5	Communicates hovering attentiveness. Vitally concerned with client's being.

SELF CONGRUENCE

1 1 1 1	Counselor clearly defensive. Striking contradictions in counselor's statement. Voice contradicts verbalizations.
2 2 2 2	Responses appropriate but protected by professionalism. Responses "sound good" but contrived or rehearsed quality.
3 3 3 3	Counselor implicitly either defensive or professional.
4 4 4 4	Neither implicit nor explicit evidence of defensiveness. No facade.
5 5 5 5	Counselor is freely & deeply himself. No defensiveness or professionalism.

A SCHEMATIC REPRESENTATION
ACCURATE EMPATHY SCALE*

Depth of client's feelings preceived & communicated by the counselor.	Stages or degrees of counselor's accuracy in preception of client's feelings.								
	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6	Stage 7	Stage 8	Stage 9
Current & most obvious feelings.	Ignores. Responds inappropriately.	Accuracy negligible. Poor understanding.	Often accurate.	Usually accurate.	Accurate	Accurate	Accurate	Always accurate.	Unhesitating. Flawless accuracy.
Non-current veiled feelings.	Unaware	Ignores	Concerned with veiled feelings but understanding poor.	Anticipates feelings poorly. Accuracy very low.	Sensitive but inaccurate. Tentative interpretations.	Accurate toward content, but not intensity. No forward movement.	Accurate toward content & intensity. Slight forward movement.	Accurate. Uncovers deep feelings. Tentative explanations & explorations.	Flawless
Deeply shrouded feelings.	Unaware	Unaware	Unaware	Unaware	Ignores	Doesn't encourage exploration.	Counselor moves on own to deepest feelings. Precise pointing out.	Sensitive trial & error exploration & explanations. Completely "with" client.	Precise in understanding & communication of it.

dapted from scheme developed by Richard Melloh, University of Florida

PERSONAL DATA
QUESTIONNAIRE

The following information is needed for research purposes, and will be kept in strict confidence.

NAME______________________________AGE_____SEX__________

MARITAL STATUS_____________________

Percentage of lifetime spent in residence in rural_______,

urban__________, or suburban___________setting.

Major_____________________________

Degrees held________________________Degrees Sought________

Sixth year certificate?_____________

Years teaching experience___________. Level taught________.

Years work experience (non-teaching)___________.

Occupation(s)____.

Number of hours credit____________. Toward what degree

____________________________________.

Number of years counseling experience______________________.

Other:

OE 6000 (REV. 9-66)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION

ERIC REPORT RESUME

(TOP)

ERIC ACCESSION NO.

CLEARINGHOUSE ACCESSION NUMBER

RESUME DATE 02-29-68 | P.A. | T.A.

IS DOCUMENT COPYRIGHTED? YES ☐ NO ☒

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TITLE
A Method of Self-Evaluation for Counselor Education (Final Report)

PERSONAL AUTHOR(S)
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INSTITUTION (SOURCE)
Univ. of Ga., Athens, Ga., Div. of Counselor Edu., College of Edu.

SOURCE CODE

REPORT/SERIES NO.

OTHER SOURCE Regional Research Program, Bureau of Research, U.S. Office of Education, Region IV, Atlanta, Ga.

SOURCE CODE

OTHER REPORT NO. OEG-2-7-070001-3140

OTHER SOURCE

SOURCE CODE

OTHER REPORT NO.

PUB'L. DATE 02-29-68 | CONTRACT/GRANT NUMBER OEG-2-7-070001-3140

PAGINATION, ETC.
viii + 78p.

RETRIEVAL TERMS
Counselor Training, Counseling Practicum, Counselor Self-Evaluation, Therapeutic Conditions, Empathy, Positive Regard, Counselor Genuineness, Therapeutic Facilitation, Psychotherapeutic Interaction Scales, Counselor Evaluation, Self-Concept Strength of Counselors, Counselor Defensiveness, Intensity & Intimacy of Interpersonal Contact, Counselor Education, Tennessee Self Concept Scale

IDENTIFIERS
Truax Scales, Therapeutic Conditions Training

ABSTRACT

A pretest-posttest control group design was used to test the value of employing four psychotherapeutic interaction scales for self-evaluation. Self-evaluation of the counselor-offered conditions empathy, positive regard, genuineness and intensity of interpersonal contact during the live counseling sessions of 44 counselors were compared with the supervisors' evaluations of the tape recorded sessions. Findings were: (1) Gain in counseling performance was significant on all scales for the experimental group but on only two scales for the control group; (2) The amount of gain for the experimental group was significantly higher than that of the control groups on only one scale (Empathy) (this held true for both experienced and inexperienced counselors); (3) Counselor/supervisor evaluations showed highly significant concurrent validity; and (4) Basic counselor personality orientations such as self-concept strength and defensiveness generally did not affect accuracy of self-evaluation.